**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

HEALTHTRUST LLC
P O BOX 890008
HOUSTON TX 77289

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**

WC SOLUTIONS

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-11-1460

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "…HealthTrust sought and received preauthorization for a multi-disciplinary chronic pain management program from this carrier…The EOB's denying these services only state that the accepted body parts are not related to the services provided even though those codes are the ones used to get preauthorization and were the codes on the HCFA's. The adjuster states that no other condition is being accepted on this claim, as if the multi-disciplinary program is a mental health related program and not a secondary treatment form for the accepted work related injury…"

**Amount in Dispute:** $31,200.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** **"**…Respondent declares that reconsideration for dates of service 10/7, 10/11, 10/12, 10/13, 10/18, 10/19, 10/20, 10/21 and 10/26/2010 has not been requested by Requestor…. The Requestor… is specifically requesting dispute resolution for 97799-CP Chronic Pain Management. The Requestor is billing for 8 units and/or 8 hours per day in the amount of $1,560.00 for the service dates listed above. Please note fee schedule in this case is $800.00 per day...The comments on the EOBs dated 11/16/2010 state: Preauthorization approval was based on medical necessity it does not guarantee payment for services or compensability of the claim. The provider was provided notice of the unresolved dispute regarding the denial of the extent of injury as required by rule 134.600(l). The pre-auth report noted an extent of injury dispute and the PLN 11's were provided to the provider. The 09/24/10 D&O affirmed the compensable injury to be a cervical strain that does not include an aggravation of cervical spondylosis causing left-side C5-C6 bulging or herniated nucleus pulposis and resulting in left upper limb radiculopathy, or an aggravation of cervical spondylosis. On 10-14-10, the DD opined that MMI was reached on 6-15-10 with 0% impairment. The medical necessity of the need for the chronic pain management program was not related to or resultant from the compensable injury.
The respondent maintains its position that CPT code 97799-CP was denied appropriately and in accordance with the TDI-DWC rules for the above referenced service dates.

**Response Submitted by**: Edwards Claims Administration; 1004 Marble Heights Drive; Marble Falls TX 78654

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 13, 2010 Through October 6, 2010 | 97799-CP x 11 days | $17,160.00 | $8,800.00 |
| October 7, 2010 Through October 26, 2010 | 97799-CP x 9 days | $14,040.00 | $7,200.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305 relates to MDR – General.
3. 28 Texas Administrative Code §134.204 sets out the reimbursement for Medical Fee Guidelines for Workers' Compensation specific codes, services, and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 6, 2010, October 21, 2010, and November 16, 2010

   - 219 – Based on extent of injury. Comments: carrier accepts claimant suffered soft tissue contusions to the following body parts: bilateral knees, right elbow, thoracic spine, cervical spine, left hip and chest only on 3/13/09. No other condition naturally resulted from or was affected by the original injury. Carrier denies all other injuries, body parts, symptoms and diagnoses which are pre-existing and/or degenerative and/or genetic, as being unrelated to the compensable event.
   - 214 – Workers compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment. Comments: per the D&O rendered 9-24-10 which states: "The compensable injury does not include an aggravation of cervical spondylosis causing left-side C5-C6 bulging or herniated nucleus pulposis and resulting in left upper limb radiculopathy, or an aggravation of cervical spondylosis."
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

**Issues**

1. Does the dispute contain unresolved extent of injury issues?
2. Does the submitted documentation support the services billed?
3. Is the requestor entitled to reimbursement?

**Findings**

1. Review of the PLN11 dated May 18, 2009 states, "Carrier accepts claimant suffered soft tissue contusions to the following body parts: bilateral knees, right elbow, thoracic spine, cervical spine, left hip and chest only on 03/13/09. No other condition naturally resulted from or was affected by the original injury. Carrier denies all other injuries, body parts, symptoms and diagnoses which are pre-existing and/or degenerative and/or genetic, as being unrelated to the compensable event."
   - Review of the PLN11 dated July 9, 2009 states, "Without waiving foregoing dispute carrier denies that the claimants' injury extends to all degenerative findings to the cervical spine as these are unrelated to the compensable event."
   - Review of the PLN11 dated October 6, 2010 states "Without waiving prior disputes, carrier disputes the symptoms of anxiety and depression. It is the carrier's position that these symptoms are unrelated to the compensable event."
   - Review of the Decision and Order dated September 24, 2010 indicates that the "claimant's compensable injury does not include an aggravation of cervical spondylosis causing left-sided C5-C6 bulging or herniated nucleus pulposis and resulting in left upper limb radiculopathy, or an aggravation of cervical spondylosis." Pursuant to §133.305, the extent of injury issue has resolved.

- Review of the bills and explanations of benefits indicates that the requestor billed with diagnosis codes 922.1(contusion of chest wall), 923.11(contusion of elbow), 924.11(contusion of knee), and 924.01(contusion of hip) all of which the carrier has accepted as compensable. There is no unresolved extent of injury issues. Therefore, the disputed health care is eligible for review per applicable division rules and fee guidelines.

2. The documentation submitted by the requestor in this dispute is reviewed. Documentation sufficiently supports that the services were rendered as billed for the compensable injury and are therefore payable under §134.204 (h) (1) (B) for a chronic pain management program.
3. Reimbursement for a non CARF accredited facility is reimbursed at 80% of $125.00 per hour according to §134.204 (h) (1) (B).
    - The requestor billed for eight hours per day times 20 days.
    - The maximum allowable reimbursement (MAR) is calculated as follows:
    - $125.00/hour x 80% = $100.00 x 8 hours/day = $800.00 x 20 days = $16,000.00.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $ 16,000.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $16,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 28, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.